The PREVENTION CONNECTION
NEWSLETTER

Adolescence: an Overview

—Dennis Cox

—I prefer to see adolescence as a significant stage in itself, an 'adolescenthood' with new experiences and new strengths, not merely an interim period and a problem. —Dr. Gisela Konopka

Adolescence is often defined as a developmental transition between childhood and adulthood. While true, it is important to recognize that it is a legitimate and unique stage of the life cycle.

We can all appreciate the difference between a 10-year-old and a 24-year-old, yet this age range bookends the developmental years we call adolescence. Commonly, adolescence is broken into three stages, 10-14 (late childhood, early adolescence), 15-19 (mid-adolescence), and 20-24 (late adolescence, early adulthood). These stages of development involve physiological, cognitive, emotional and spiritual changes that affect the youth as well as their relationships with their families, friends, and communities.

Younger adolescents tend to think of moral issues as right and wrong or good and bad according to external, conventional standards and rules (Green and Palfrey 2002).

In early and mid-adolescence (roughly age 11 to 17), teens experience profound changes in their cognitive abilities. During these years, adolescents move from concrete thinking, which focuses on immediate concerns, to formal operational thinking, the ability to think in the abstract and to construct hypothetical "what if" scenarios. Their sense of morality is changing in a similar fashion. The areas of the brain that are developing and changing during the adolescent years control such things as planning, impulse control, reasoning, processing mental tasks, and modulating of mood (National Institute of Mental Health 2001).

As adolescents leave behind the comfort of dependency, relative safety and the well-defined boundaries of childhood, they struggle toward independence and self-reliance. Searching for a sense of identity, awkwardness of self and body, moodiness, self-absorption, stress, experimentation with appearance, risk taking, development of critical thinking skills, parental resistance, increased ability with language and expressive skills; these are the developmental footprints left along the trail of the adolescent's journey toward independence.

In working on these tasks, young people typically begin to question parental values and belief systems and look to their peer groups for support and reinforcement of values, attitudes, and behaviors. Adolescents also undergo profound changes in their emotions, changes that may seem erratic or unexplainable to those around them (Green and Palfrey 2002). As they mature, adolescents begin to internalize the values of the society around them and become able to formulate and follow abstract moral principles.

Youth culture has a significant impact on the behavior of adolescents as they search for a sense of belonging. They practice a common language and belief system;

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The Vicki Column

Adolescence is sometimes defined as the transition between puberty and adulthood. It could as easily be defined as a personal labyrinth fraught with unknowns. For some, the twists and turns are difficult and painful, but manageable. Coping with dramatic biological changes, complex social scenes, high expectations and accelerated learning rates can all be difficult. Making it eveh harder can be the temptation to experiment and to rebel.

While most teens ultimately find their way out of the labyrinth, others incur lasting damage. These young people may not be able to gain enough perspective to realize that adolescence is a temporary phase. Instead, they may see it as a step toward a painful and difficult future.

Best practice youth development programs offer the tools young people need to grow into healthy, hopeful adulthood. These include support from caring adults, a sense of opportunity, and the chance to develop skills. Young people need a sense of achievement, belonging, and a way to contribute to their communities. These coalesce into the self esteem needed to function in the world of adults. This issue of the *Prevention Connection* touches on all of that and some extremely difficult teen issues: aging out of foster care, dealing with addiction and teen parenthood, and the incarceration of a parent.

Lifelong habits that promote health—or risk—are often initiated during adolescence. A lot of good work is happening in Montana that ensures young people make the right choices or have the opportunity to recover from the wrong ones. Ultimately, the bottom line is that we must continue our work to ensure our adolescents have what they need.

Vicki

Building a Better Tomorrow

—Governor Brian Schweitzer

My wife, Nancy, and I have three teenagers, and we think Montana is absolutely the greatest place in the world to raise a family. Even so, as parents, we worry about the many challenges teenagers face these days.

Right now every community in Montana is seeing the horrendous effects of methamphetamine. Meth is one of the greatest challenges we've ever faced and our children are right in the middle of it. Children live what they learn. Children who live in homes where substance abuse is the norm emulate it.

One of the best ways we can break a cycle of substance use is to help families and to emphasize the power of prevention. That means teaching youth about the risks to using drugs and the benefits to making healthy decisions. We need to give our children and their families a sense of hope that there's a chance for a better tomorrow, so that young people will have good reason to invest in themselves and in their futures.

Education is one of Montana's most important tools for offering hope to young people and helping to build the state's economy. Our investment in education starts the first day a child walks up to the schoolhouse door for kindergarten. Our investment must continue through high school and on to college, so that our children have the opportunity to one day raise a family in Montana.

Montana is certainly a state of dreamers, but we are dreamers who are well-grounded in reality. We know that we not only need to hold onto our own dreams, we need to instill them in our children. There is a direct link between hopeful dreams and healthy choices. Youth who care about tomorrow can be guided to make healthier choices today and every day . . . to choose healthier foods, to exercise, to avoid tobacco, to stay in school. Just as one poor decision can lead to another, one healthy choice can lead to a bright future. I can't think of a better hope for Montana's children—our future—than that.

Adolescence

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express shared customs, traditions, arts, and history, such that they define themselves by those attributes. This is where youth gain a sense of self-identity and relationship to community, as well as form their attitudes toward differences in race, religions, ethnicity, and cultures.

From a public health perspective, adolescence is a relatively healthy period. The main focus is on preventable health issues that broadly impact our youth population. Prevention of negative outcomes is primarily behaviorally based. Health habits formed during adolescence will set the pattern and continue into adulthood. Healthy People 2010 identified 21 Critical Health Objectives for Adolescents and Young Adults. These objectives focus on the areas of mortality, unintentional injury, violence, substance use and mental health, reproductive health, and the prevention of chronic disease during adulthood.

Most research shows that negative health outcomes—including suicide, violence, pregnancy, and substance abuse—are influenced by multiple factors, each of which incrementally increases the risk of poor outcomes. Many of these outcomes share the same risk factors. In other words, poverty, poor academic achievement and suicide in the family put youth at risk for multiple problems. This understanding has profound program and policy implications.

Positive youth development is an approach to structuring services, supports and systems around youth to emphasize their strengths and build their resiliency by increasing assets while reducing risk factors. This approach assists youth in developing the skills and competencies needed to successfully enter adulthood.

The main goal of positive youth development strategies is to help youth become socially, morally, emotionally, physically, and cognitively competent. Youth development strategies help youth become healthy, productive adults by supporting the development of the attitudes, behaviors, and skills that enable them to succeed as parents, citizens, and workers.

According to Dr. Gisela Konopka, the following are the Fundamental Requirements for Healthy Youth Development. Youth need the opportunity to:

— participate as citizens, as members of a household, as workers, and as responsible members of society.

— gain experience in decision making.

— interact with peers, and acquire a sense of belonging.

— reflect on self in relation to others, and discover self by looking outward as well as inward.

— discuss conflicting values and formulate one's own value system.

— experiment with one's own identity and with relationships; try out various roles without having to commit irrevocably.

— develop a sense of accountability in the context of a relationship of equals.

— cultivate a capacity to enjoy life.

Recently, Dr. Konopka added another requirement to the list. Adolescents need the opportunity to participate in the creative arts, to learn self-expression and to communicate deep feelings from within.

Programs that emphasize the principles of positive youth development are predominantly promising programs that demonstrate these best practice approaches. These include such programs as Safe Schools/Healthy Students Initiative; Girl Power; 21st Century Community Learning Centers; 4 H Club; Boys and Girls Club; and AmeriCorps.

For more information about programs in your area or information on how to get a program started, contact Dennis Cox at 406-444-6928 or DKCox@mt.gov.

—Dennis Cox has a Master's Degree in Applied Behavioral Science and 20+ years experience in the field of children's mental health in venues that include residential treatment, group homes and therapeutic foster care. He was also in private practice for ten years as a youth and family therapist.

Interagency Coordinating Council (ICC)

Mission: To create and sustain a coordinated and comprehensive system of prevention services in the State of Montana.

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Notes From the Edge:
Lost and Found

—Sharon Patterson

According to a U.S. Senate Report, the children of prisoners are six times more likely than other children to be incarcerated at some point in their own lives. Losing a parent in this way fractures a child's sense of stability and security. This loss creates special problems as well as specific needs. *Beyond the Circle* Mentoring Program and Camp Sky Child were created to help fill the void caused by this loss. A healthy, nurturing and dependable adult role model can provide some of the developmental support children need to find stability and learn hope.

I was a leader at Camp Sky Child in 2004 when I first discovered a reality intrinsic to children who have been victims of trauma, a reality that throws long shadows. In hearing and observing the girls staying in my cabin, I caught a glimpse of lives and worlds very different from my own. I also had the opportunity to see the potential behind the armor they worked very hard to hide behind.

Camp Sky Child is a summer camp for children who have a currently or previously incarcerated parent. This situation, as I soon discovered, is just one of many situations that contribute to the problems these children face. Children who have an incarcerated parent often face poverty, violence, educational challenges and psychological issues—all of which can lead to various difficulties in their lives.

A couple of the girls staying in my cabin gravitated to me—as I did to them. We developed a special connection that summer, and spent the long days hanging out, laughing and talking. At the end of the week, I realized I didn't want to lose touch after camp. I spoke with the camp director, Deb Kottel, and asked how I could continue to play a part of the girls' lives. Deb introduced me to the Beyond the Circle Mentoring Program.

I chose to mentor the two girls I'd enjoyed so much. Beyond the Circle staff schedule regular group activities throughout the year. The girls and I also spent time together outside those activities. As we came to know one another better, they began revealing their interests and dreams to me. And sometimes—often in the most unlikely places—one would suddenly pour her heart out, revealing the details of a painful past.

"I just want to be loved . . . unconditionally," one of them said. Growing up, I'd gone through plenty of stressful situations, but I had parents who guided me through and helped me discover ways to deal with adversity. Her simple wish touched me. I had always had the luxury of taking my parents' unconditional love for granted.

Another time we stopped at my house to make some telephone calls. I pressed the garage door opener. When the door rose, the girl beside me was in awe. She'd never seen an automatic garage door and wondered aloud if it could go down as well.

It's at times like that that I realize that everyone doesn't inhabit the world I live in, that not everyone has had the same privileges and opportunities I've enjoyed.

Beyond the Circle has opened my eyes. This isn't just about doing something good, being part of building my community or having fun with a couple of girls. It is all of those things, but it is also infinitely more. It's about the relationships, coming to know one another well enough to share joy and dreams . . . and to begin to understand the sense of hopelessness that throws long shadows across lives.

I hope I can adequately express to these girls that they are valuable, worthy—and that it is possible to be loved unconditionally. I want these girls to know there is a world out there worth reaching for.

Maybe, through mentoring, part of something lost can be found. Maybe they can begin to see the world as I see it . . . with hope.

Corrections

Nearly 90 percent of the inmates at Montana Women's Prison (MWP) participate in a parenting program staffed by volunteers.

Corrections Demographics

The overall daily average of adult offenders in Fiscal Year (FY) 2004 was 10,353. This is a 4.4 percent increase from FY 2003.

— 255 were in intensive supervision

— 632 were in prerelease centers

— 2,654 were in secure custody

— 6,813 were on probation and parole

The top offences for 1995-2004:

— Males: theft

— Females: possession of drugs

Source: *http://www.cor.state.mt.us/*

A note from Sharon's mentee

I think that being in the mentoring program is fun. It teaches me to help my parents out and to balance money. My mentor would give me like $50 dollars to buy shoes. I would buy $39 dollar shoes and some socks. That taught me a lot. I also like that she bought me books from Barnes and Noble and I got this cookbook and we got the ingredients and we made dinner. That was good. She made a good impact on me. I would like to stay in this program. It is so fun. It showed me so much. I love it so much.

—Angie, age 14
Great Falls, Montana

The Role of Recognition

—Andrew Laue, LCSW

—Strong and resilient self-identity is never forged in isolation, as humans ar eessentially relational creatures who are dependent upon one another's responsiveness in order to grow.

Adolescence—the years between latency and young adulthood—are characterized by intense surges in physical, emotional, and social growth that eventuate in the growing self establishing an independent and autonomous identity. For this development to be successful, this self must be able to define, nurture and protect itself. Second only to early childhood in being a decisive developmental period in the life of a self, adolescence is a time when the responsiveness of parents, family, and community are essential in the growth of the unfolding individual.

Gaining recognition in the eyes and heart of "the other" is an essential component in the ability of the youth to build the core foundation of an open and resilient sense of self. This aspect of adolescence is so critical that the period is characterized by an identity forming response in which young adolescents consolidate group identification and identities characterized by sameness. This sameness has the purpose of easier identification and recognition of an individual identity in the context of an accepting group. Peer group identity becomes a key indicator of safety.

For young adolescents who experience some deviation from social norms in the process of identity formation, relying upon peer group and family recognition for the support of their unfolding selves can be precarious. The formation of gender identity and sexual orientation and identity are a key task of this developmental period. Without being able to rely upon the sameness of peers to support the unfolding self, the young Lesbian, Gay, Bi-sexual or Transgendered (LGBT) adolescent is often faced with a difficult developmental path characterized by aloneness, confusion, feelings of shame and doubt, rather than the confidence and hope that come from being recognized in the eyes of the other. Increased suicide rates and the predominance of mood disorders in the lives of these youth are markers of the difficulty of their developmental path through an unsupported and nonresponsive adolescence.

Critical to the support of these unique adolescents is an accurate awareness of their relational and developmental dilemmas. Often, their difficulties are explained in other terms within their social milieus, so that their true dilemmas are overlooked. Moralizing positions that demonize difference and see diversity of sexual orientation or gender identity as essentially wrong or immoral place a disabling burden on the adolescent and obscure the responsibility of the "holding environment" to perform its recognizing and supportive functions. Developmental positions that perceive the diversity in the adolescent as faddish or temporary miss the foundational aspect of identity formation, and tend to interpret manifestation of identity formation as flamboyant or extreme behavior.

What must be affirmed is that all adolescents are establishing the core of their identities during this dynamic period and they must be recognized with openness and seriousness.

The adolescent differentiates herself from the parental and social norms around her and often creates sharp ideological disagreement with the family system. Recognizing the adolescent should not be mistaken for simple agreement or approval. It is possible to provide strong, authentic recognition at the same time that disagreement about issues of identity diversity are maintained. It is the responsibility of the adolescent to grow a strong sense of identity, even if this identity is in contradiction with prevailing norms in the familial or social context.

It is important that families and communities step toward the LGBT youth during adolescence to provide recognition and support. A response of recognition that confirms the seriousness, the importance, and the value of these identity questions are important. Families uncomfortable with LGBT issues themselves or who are discouraged or confused by this knowledge of their children's identity struggles, can gain support in helping their children and themselves step toward these issues with seriousness and openness. Individual counseling can be helpful. The recognition and inquiry present in the counseling relationship establish a firm basis for the adolescent's beginning self-recognition.

Educational and social support groups in the school and community setting are key to providing recognition for the legitimacy of diversity and to affirm the developmental paths of those outside social norms. Serious dialogue with spiritual leaders enables the adolescent to see his/her own developmental path against the backdrop of spirituality and in context with aspects of ultimate concern. The support of vocational and educational opportunities for these youth helps stabilize the ability to protect and nurture themselves.

When an LGBT youth steps toward his community for recognition and support, it is essential that he is engaged with seriousness, respect, openness and regard. If responded to in this manner, the potential of this young person to grow into a strong, resilient, unique member of the family and community is greatly enhanced, and the family and the community are also strengthened.

—Andrew R. Laue, LCSW, is in private practice in Missoula. He can be reached at laue@blackfoot.net.

Youth Suicide

—Dennis Cox

Montana's suicide rates are among the highest in the nation and the overall rate has not declined in suit with the national trend. According to Montana's Strategic Suicide Prevention Plan (revised 2003), suicide is the second leading cause of mortality among Montana's youth and young adults, with motor vehicle crash deaths causing the most deaths among 15-19 years olds.

Montana follows the same gender pattern as most of the United States. Montana males are most at risk for death from suicide; however Montana females are about five times as likely as males to attempt suicide. This is because more females choose reversible means such as poison, and more males choose irreversible means such as firearms.

In 2003, 19 percent of high school students participating in Montana's Youth Risk Behavior Survey (YRBS) answered "yes" when asked if they had seriously considered suicide in the past 12 months; 78 percent of those considering suicide had actually made a plan to attempt it—and 10 percent of *those* reported they had attempted suicide at least once during the last 12 months. Nearly 4 percent of the students reported two or more attempts during this time period. The 2003 YRBS also revealed that 26 percent of high school students in Montana felt so sad or hopeless almost every day for at least two weeks that they stopped doing some usual activities. This rate rose to 30 percent for students on Montana's Native American Indian reservations.

Tragically, although there are many signs (see sidebar), they often go unrecognized. While suffering from one of these symptoms certainly does not necessarily mean that one is suicidal, it's always best to communicate openly with a loved one who has one or more of these behaviors, especially if they are unusual for that person.

Suicidal thoughts, ideation, and threats should always be taken seriously. Statements like "You'll be sorry when I'm dead" may be said off-handedly or seemingly in jest, but must not be minimized.

Communication is vital if you suspect that someone is contemplating suicide. Question, Persuade and Refer (QPR) is recognized nationwide as a best practices program that offers *gatekeeper training* to parents, students, teachers, and community service providers on how to stay in communication with an individual who may be contemplating suicide and guide him/her to professional help.

Youth suicide prevention is a Montana priority. Over the last five years, the Department of Public Health and Human Services has made several efforts toward reducing youth suicide. Some of these include a Suicide Prevention Task Force, a suicide crisis line, and numerous community efforts. The Child, Adolescent, and Community Health Bureau received $50,000 in Preventive Health Block Grant carry-over funds. Five new or continuing sites in local communities will be awarded mini-grants for youth suicide prevention projects. In May 2005, DPHHS applied for Youth Suicide Prevention and Early Intervention funds, which will potentially fund up to 15 communities for youth suicide prevention programs.

It is important to remember that adolescent and young adult suicide is a public health problem that is preventable.

For more information, contact Dennis Cox, Adolescent and School Health Consultant, 406-444-6928 or DKCox@mt.gov.

Warning signs

According to the National Alliance for the Mentally Ill (NAMI), there are a number of behavioral indicators that can help parents or friends recognize the threat of suicide. Since mental and substance-related disorders frequently accompany suicidal behavior, many of the cues to are symptoms associated with such disorders as depression, bipolar, anxiety, disruptive behavior and borderline personality disorders, alcohol and drug use, and schizophrenia.

Common symptoms include:

— Extreme personality changes

— Loss of interest in activities that used to be enjoyable

— Significant loss or gain in appetite

— Difficulty falling asleep or wanting to sleep all day

— Fatigue or loss of energy

— Feelings of worthlessness or guilt

— Withdrawal from family and friends

— Neglect of personal appearance or hygiene

— Sadness, irritability, or indifference

— Having trouble concentrating

— Extreme anxiety or panic

— Drug or alcohol use or abuse

— Aggressive, destructive, or defiant behavior

— Poor school performance

— Hallucinations or unusual beliefs

Adolescent Health in Montana

—Dianne Frick

Every five years, the Department of Public Health and Human Services compiles a Maternal Child Health (MCH) Needs Assessment for Montana. The assessment collates information gathered through a survey, as well as maternal and child health data collected by programs and activities during the preceding five-year period.

For the 2005 MCH needs assessment, parents, physicians, school and county health nurses, Head Start and WIC staff were surveyed about health needs among infants, children, adolescents, pregnant women and recent mothers. The same needs emerged as priorities for adolescents in every region and size of community: alcohol and drug abuse prevention and treatment; access to dental care; pregnancy prevention; mental health services; health insurance; and access to health care.

Sexual health education, tobacco use prevention and treatment and obesity prevention were also frequently identified as priority health needs for adolescents. These results illustrate differences between the health outcomes of Montana teens and their nationwide peers, and underscore health risks among Montana teens.

Injury and Violence

The 2003 Youth Risk Behavior Survey (YRBS) indicates that Montana students feel safer at school and are less likely to be threatened with violence or engage in a fight at school than their national peers. However, Montana youth were more likely to have frequent access to firearms than other U.S. teens, and a higher percentage were intentionally physically hurt by a boyfriend or girlfriend.

Motor Vehicle Crashes

Between 2000 and 2004, motor vehicle crashes were the most common cause of death for teens ages 15-19, accounting for approximately 48 percent of teen deaths. The combination of alcohol use and motor vehicles is of particular concern in Montana. The 2003 YRBS reported that 36.9 percent of teenagers had ridden with a driver who had been drinking within the past month, as compared to 30.2 percent nationally. More than 20 percent of Montana teens reported that they had driven a vehicle after drinking alcohol within the past thirty days, versus 12.1 percent of teens throughout the nation.

Suicide

Suicide has consistently ranked as the second leading cause of death in Montana youth (ages 10 - 24) over the past decade. The rate of youth suicide in Montana has decreased, but remains higher than the national average. Firearms are the most common cause of death among suicides in Montana.

Physical Activity and Obesity

According to the 2003 YRBS, youth in Montana are as—or more—active than their peers nationally, but a comparison of 2003 YRBS results with previous years indicate that Montana youth have become less active since 1999. In 2003, 62.3 percent of youth exercised or participated in vigorous physical activities for at least 20 minutes on three or more days during the previous week, as compared to 69.5 percent in 1999.

Tobacco Use

The percentage of teens smoking in 2003 was similar to the national percentage. Almost 23 percent of Montana teens reported smoking cigarettes during the last month (YRBS), compared to 21.9 percent of U.S. teens, but a higher percentage of Montana youth who were current smokers reported trying to quit during the past 12 months. Conversely, Montana youth were almost twice as likely to report using chewing tobacco or snuff compared to their national peers.

While several adolescent health indicators show that Montana is doing well, our youth continue to face critical health issues. The MCH assessment results provide a guide to address areas where adolescents are at most risk and maintain the health status in those areas where Montana youth have positive outcomes.

For more information, contact Dianne Frick, Public Health Prevention Specialist, at the Family and Community Health Bureau: dfrick@mt.gov *or 444-6940.*

Vital Statistics: Montana Adolescents

Montana's Adolescent Mothers:

Ages 13 – 18

(The information below reflects 5-year ***averages*** *for 1999 – 2003)*

—Induced abortions: 325

—Live births: 744

—Fetal deaths: 4.2

Vital Statistics: Leading Causes of Montana's Adolescent Deaths:

Ages 13–18

(The information below reflects 5-year ***totals*** *for 1999 – 2003)*

—All causes: 290

—Accidents: 186

—Intentional self harm (suicide): 48

—Cancer: 14

—Assault (homicide): 9

Data courtesy of the Office of Vital Statistics Data: Montana Department of Public Health & Human Services

Mountain Home Montana: *a Second Chance Home*

—Gypsy Ray

Youth homelessness has been an unaddressed problem for as long as I have worked in the social work field. There is an assumption that homeless youth are part of homeless families, but the truth is, there are a large number of homeless youth between the ages of 14-21 on their own, including teenage parents. Youth face unique barriers to housing because they lack resources and need services designed for their developmental needs. It is critical that resources are put toward this effort to prevent youth from becoming chronically homeless adults.

Through the dedication and passion of the Board of Directors and the community of Missoula, the non-profit organization, Mountain Home Montana, Inc. was founded to meet the needs of homeless teenage mothers. Mountain Home Montana opened Montana's first Second Chance Home in Missoula in 2000 thanks to Bonnie Hamilton's generous gift of her family home. This residential program provides a unique service in Montana, providing services to homeless teenage mothers who do not qualify for other services due to their age or lack of funding sources.

The facility is located on one-acre and has six bedrooms, three bathrooms, a kitchen, dining room, living room, playroom, offices, storage and a play yard. Mountain Home Montana is staffed by an executive director, a case manager and shift workers who provide 24-hour supervision and support. Four beds are reserved for homeless teenage mothers, leaving two beds for other referrals. These beds are often filled with the homeless as well. Mountain Home Montana provides family style dining, and coordinates on-site parenting classes, life skills classes, nursing services, therapy and other social services.

—Gypsy Ray is the Executive Director of Mountain Home Montana in Missoula. She can be reached at 406-541-4663 or gypsyray@blackfoot.net. For more information visit Mountain Home on the web at: www.mountainhomemt.org

Mission: Mountain Home is committed to providing a home and supportive services to homeless young women aged 14-19 who are pregnant or parenting one child. Participants access community resources, learn independent living skills, develop parenting skills, continue their education and improve their employment skills in order to obtain permanent housing and ultimately to be self-sufficient.

In coordination with the University of Montana, Mountain Home completed a 3-Year Program Evaluation from 2000-2003. The results demonstrate that Mountain Home Montana *is* making a difference in the lives of teen mothers and their babies. The full report is available at Mountain Home Montana's website at *www.mountainhomemt.org.*

Statistics: 2000-2004

- *Teen mothers served: 82*
- *Average age: 17*
- *Referrals from Missoula: 50%*

The 3 R's: *a strategy for working with teen mothers*

—Cindie Woods

1. Relationship

- The number one factor in working with teen mothers is *relationship*, the basis of all human interaction.
- Listen, be open-minded and honest, build trust and be available.
- The stronger the relationship you build, the more you will be trusted and turned to for help.
- Keep in mind that these young women have not experienced healthy relationships. You may be the first person who has ever listened and taken the time to care (adults have been their abusers).
- Have passion for your work.

2. Respect

- Be honest, even if it is uncomfortable.
- Do not judge, even when they make poor choices (most of their behaviors are developmentally appropriate).
- Show respect and most often they will reciprocate.
- If they know you respect them, they will tell more, ask more and learn more.

3. Reality

- Teen pregnancy and parenting is real.
- The U.S. has the highest teen pregnancy rate in the industrialized world.
- Whether or not our country or state believe teen pregnancy is an important issue, it is happening and it is not going away.
- Abstinence will help delay sexual activity among some teens, but it will not solve the complex issue of teen pregnancy.
- The reality is that society needs to come together and work to prevent teen pregnancy in a realistic way and to fund programs that set teen mothers up for success.

— *Cindie Woods is a case manager for Mountain Home Montana in Missoula.*

Youth Homes, Inc.

—Geoff Birnbaum, Executive Director

In 1971, it seemed simple: open a group home as an alternative to institutions and things would get better for kids and the community. We opened a seven-bed boys' home with house parents and the hope that we could help. What a journey it has been! In the interim since 1971, the Youth Homes have helped more than 8,000 young people.

Youth Homes, Inc. cares for at-risk children and youth and/or youth whose families are in crisis. Children come with emotional, social, protection, legal and chemical dependency issues and are referred by public agencies and families. As an agency, Youth Homes, Inc. is committed to serving youth in a community closest to home. We provide placement, counseling, recreation, cultural opportunities and access to community resources. Most youngsters served attend nearby public schools. Our program offers a variety of family options and serves upwards of 140 children each day, through permanency care, therapeutic foster care, adoptive services and guide homes, all designed to assist with positive transitions back to the community. The homes serve children as young as two and as old as 17.

Group Homes—Many children who have suffered tremendous loss act out in a variety of ways. The goal of our group homes is to help the youngsters make enough progress through care, guidance and treatment that they can succeed in a family setting. We have four long-term group homes for adolescents in Missoula County. Three are treatment homes, and one serves youngsters in need of a home-like setting as they prepare for emancipation. The treatment homes serve youth with serious emotional difficulties, many of whom are involved with youth court and child protective services. One facility serves each gender; one is coeducational. The age range served is 11–17. Each serves four or six residents, and has counselors and therapists in-house. Together the homes serve a daily census of up to 22 youngsters.

Shelter Care—When families are in conflict, children often become homeless. Attention Homes offer shelter and attention to kids who have been on the street. The first Attention Home was established in 1976. Today there are three: one each in Missoula, Kalispell and Hamilton. Each provides a safe, stable, home-like environment from which kids can rejoin the community, reunite with their families, resolve crisis and/or develop plans to meet their long-term needs. Shelters are eight-bed homes located in neighborhood settings; in-home counselors work with the youngsters. Homes serve a daily census of up to 23 youngsters, ages 11–18.

Through the **Street Outreach** program, a counselor from the Missoula Attention Home lets youngsters in shelter or on the streets know that someone cares, helps them connect with services, reunite with their families or find placements.

The **Dan Fox Foster Care and Adoption Program** starts by searching for families willing to make room for a child, then screens, trains and licenses those families. The program simultaneously determines if a child is ready to live with a family again. Since 1991, children and families have been matched when need, placement, availability and timing are right. The outcome provides tremendous opportunities for the child and family.

The **Missoula Learning Lab** was established in 1993 to provide an educational setting for youngsters who had withdrawn from school. It has full computing capabilities and is located within the local Alternative High School. The 10-student lab supports individualized instruction by a certified teacher; students receive credit while doing work from their home districts or as they study toward a GED.

InnerRoads Wilderness Program teaches youngsters to deal with emotions, resolve issues, and make life decisions in wilderness settings. The program offers four weeks of wilderness travel and skills, and two weeks of camping near the community to engage in service learning. Therapists provide individual, group and family therapy before, during and after the time in the wilderness. Family reintegration is followed by supportive mentoring for the balance of the school year. Groups of five adolescents, ages 13-17, are assisted by three instructors, a program director and program therapists. This project was assumed by the Youth Homes in February 2005 and will serve ten families.

—Through 35 years of experience, we have grown in our understanding of what children and youth need to achieve success over the long term. This has led to the growth of in-home therapy, increased activities that support child development, and other services.

For more information, visit Youth Homes on-line at www.youth homes.com *or call 406-721-2704.*

Youth Homes Inc.

MISSOULA POLSON KALISPELL HAMILTON HELENA

New Choices

—Mona L. Sumner

Rimrock Foundation has long had a contract to serve addicted, indigent youth at its main facility in Billings, but May 31, the foundation opened *New Choices*, Montana's first residential group treatment home for indigent, drug-addicted adolescents. New Choices houses males ages 13-17; girls remain at the main facility. Youth over 17 are evaluated to determine whether adult or adolescent program is a more appropriate fit for their individual needs.

In the addiction treatment continuum, residential care typically means services are provided in a non-medical setting and without medical oversight. *New Choices* has the best of both worlds. It is located in a residential setting in a newly refurbished home on a large, private lot. New Choices is within a three-minute drive from the main facility, so medical personnel are immediately available. Historically, over 60 percent of the adolescents treated under our state contract with the Addictive and Mental Disorders Division have co-occurring disorders that require psychiatric evaluation and oversight. These services are also readily available to residents.

New Choices mirrors the Foundation's longstanding adolescent program and is designed to address the special clinical needs of young patients, their parents, and significant family members whose lives have been impacted by the adolescent's abuse of substances. While addiction is a primary illness, adolescent substance abuse may represent a disturbance in the developmental process rather than true physical addiction. For this reason, it is necessary to conduct a careful assessment of the pattern of use, state of adolescent development, and social milieu. Quality treatment must address the comprehensive biopsychosocial needs of the adolescent.

To accomplish this, several treatment components are organized into a comprehensive program designed to interrupt the harmful involvement with substances and restore the youth to appropriate developmental progress. Group therapy is the primary modality employed within the program, with individual therapy provided weekly or more often as needed. Special topic groups are tailored to address developmental stages and needs. They address issues relative to sexuality, values and choices, peer pressure, problem solving and relapse prevention. Experiential learning through a variety of mediums places emphasis on responsibility, team play, respect, and service to others. When a youngster demonstrates any of these values, he receives merit points that accumulate to earn a weekly outing.

Two other special group experiences are offered. The weekly *Animal Encounters* group is a two-hour outing with horses. The boys also help with the pets at the animal shelter. In this setting, the kids get in touch with abandonment and loss. The Youth Stewards program is another weekly opportunity. The kids adopt a park and spend an hour and a half engaging in community service, which makes the service concept underlying the twelve step program real for them. Our kids also go to community-based 12-step meetings.

An intensive week-long family program is provided monthly. Families obtain therapy and learn the skills they need to cope. During the school year, residents are in school with a certified teacher. During the summer, the teacher offers a life skills program that includes skills such as managing a checkbook, interviewing for and holding a job. Recreation opportunities occur four times a week and include a fitness program, and outings where kids experience fun without chemicals. Golf, the zoo, and—in the summer—learning to tie their own flies and fishing are all favorites.

Our program lasts at least five weeks, and many kids stay longer. We welcome referrals for children and youth from families with incomes up to 200 percent of poverty. We are very excited about this program, so please call with questions or to discuss a referral at 1-800-227-3953 (Billings, 248-3175).

For more information, contact Coralee Goni, M.S., LAC, at Rimrock. She supervises New Choices *and is available to discuss your referral needs, as are others on staff at the Foundation. If you are in Billings, we are also happy to schedule a tour of the facility, which is located at 1220 Poly Drive.*

—Mona L. Sumner, M.A.C., M.H.A., is the Chief Operations Officer/Clinical Director for Rimrock Foundation.

The Needs of Adolescents in Treatment

— In treatment, adolescents must be approached differently from adults because of developmental issues, differences in values and belief systems, environmental considerations such as strong peer influences, and educational requirements.

— Treatment approaches should account for age, gender, ethnicity, cultural background, family structure, cognitive and social development, and readiness for change. Younger adolescents have different developmental needs than older adolescents, and treatment approaches should be developed appropriately for different age groups.

— Treatment should involve family members because family history may play a role in the origins of the problem. Successful treatment cannot take place in isolation.

— Treatment providers should have specific training in the principles of adolescent development, and treatment programs should avoid mixing adult clients with adolescent clients.

Summary of Key Points from SAMHSA's Treatment Improvement Protocol on Treatment of Adolescents with Substance Abuse Disorders. http://www.health.org/govpubs/rpo996/

Teen Recovery Center

—Cheri Peterson

Many of us look back to our youth with fond memories of simpler times, of spreading our wings and testing our limits. Life has gotten more complicated in the past few decades. Today's adolescents face greater challenges than did teens of past generations. As anyone who works with adolescents recognizes, pressures are placed on youth to experiment with drugs, sex and other illicit behaviors at an earlier age than ever before.

Since 2000, the State of Montana has been at the top of the national list for alcohol, tobacco and other drug use by teens (Montana Prevention Needs Assessment). While alcohol and tobacco use has dropped slightly (from second highest nationally to fourth, and fourth highest to sixth, respectively), illicit drug use by teens remains the second highest in the nation. Use spikes between 8th and 10th grades and continues to climb throughout high school.

Many teenagers are filtered into the alcohol/drug education classes mandated by legislators. Maneuvering the court system with an alcohol ticket is often enough of a wake up call, especially when coupled with the temporary loss of the driver's license. Some of these teens are recommended for outpatient treatment, and of those, some will benefit from treatment coupled with family support and skills to resist peer pressure. Others will struggle to overcome the pull of addiction, and flounder in their attempts to get clean and remain drug-free. Often, there is little support for their sobriety from friends, community and family.

Drug addicted teens will now have more options available to help them beat their addiction and get their lives on track. The Teen Recovery Center (TRC), a residential program for adolescents, will be available in Missoula. Situated in a picturesque rural setting, the TRC will house ten adolescents with chemical dependency problems, with or without co-occurring mental health issues. In the past, bed space for indigent, addicted kids was limited to four beds, which later dropped to two. The waiting list was often months long. Eight of the ten beds at TRC will be for indigent teens.

While residing at the Teen Recovery Center, adolescents will participate in individual, group and family therapies. Initial intervention techniques will utilize motivational enhancement strategies to match the individual's level of motivational development. Subsequent strategies will shift the focus to a cognitive behavioral approach, and facilitate further change. Weekly family involvement will provide analysis of family dynamics, dysfunctional roles and offer skills for change on a systems level.

During their stay, teens will have the opportunity to continue their educations. A teacher will be employed and residents will attend school on site. Individual Education Plans will be utilized to provide the teens the opportunity to succeed in school. TRC will also work with Western Montana Mental Health Center Child and Family Service Network for services related to behavioral health. Youth will participate in activities designed to enhance basic communication and interpersonal relationship skills as well as develop healthy leisure-time skills. A spectrum of opportunities will be available, running a gamut from swimming and rock climbing to computer skills and reading.

The goal of the TRC is to improve the lives of teens and families. Struggling with addiction greatly strains family relationships. The TRC will provide a safe, structured environment to help our youth recognize the need to change and to develop the skills necessary to work toward recovery. Family therapy and involvement will encourage family members to develop communication skills and to reconnect. As teens leave our facility, they will step down to a lower level of care and follow-up services.

Montana's teens are a precious commodity. If you would like to learn more about the Teen Recovery Center, call 406-543-4768 or contact Turning Point at 406-532-9800.

New Index Predicts Drug Abuse Vulnerability in Adolescent Boys

Researchers at the University of Pittsburgh's Center for Education and Drug Abuse Research identified characteristics that appear to predict a boy's vulnerability to substance use disorder in young adulthood. This new construct, "neurobehavioral disinhibition," may help clinicians tailor drug abuse prevention programs for children most in need of support.

Compared to his peers, a "disinhibited" child can be described as difficult. His (or her) moods are volatile, and he often exhibits restlessness and an inability to persevere in a task. Poor self-management often reveals itself in risky, even reckless, behavior. Neurological tests reveal a lack of certain capacities that originate in the part of the brain that manages higher-level thinking.

National Institute on Drug Abuse: http://www.nida.nih.gov/NIDA_notes/NNvol19N2/New.html

Aging Out of Foster Care

—Jane Wilson and Samantha Walsh

As they transition into adulthood, youth who have histories of foster care face more challenges and experience more unstable living conditions than other youth. This year, two major studies on the outcomes of foster care youth were released. *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study*, was published by the Casey Family Programs (March 2005), and the *Midwest Evaluation of the Adult Functioning of Former Foster Youth* (May 2005). Both studies provide insight into how foster youth fare as adults and suggest changes that have implications for successfully transitioning foster youth from care.

The Findings

Mental Health: Both studies found that foster care alumni experience mental health and substance abuse problems at far greater rates than their peers in the general population. Key findings from the Northwest Study indicate that 54.4 percent of foster care alumni suffer from one or more mental health problems. The rate of post traumatic stress disorder is nearly double that of the general population. Over 20 percent of foster care alumni had experienced major depression and 17.1percent suffered from social phobias. Recovery rates for many disorders, however, were similar to those found in the general population.

Involvement with Criminal Justice: Nearly two thirds of the male youth surveyed and half of the females in the Midwest study were found to have been involved in the juvenile justice system; 28 percent reported having been arrested and 20 percent incarcerated.

Education: While 84.8 percent of alumni in the Northwest study had completed a high school degree or GED program, only 1.8 percent had completed bachelors degrees. Of those 25 or older, 2.7 percent held bachelors degrees. The Midwest Study found that 19-year-old youth in the national sample were significantly more likely to be enrolled in an educational program than foster care youth. Over one third of the alumni sample did not have a high school degree or a GED, as compared with 10 percent of the national sample.

Employment and Finances: In the Northwest study, 22 percent of foster care alumni had been homeless for one or more days, and 16.8 percent were receiving cash assistance at the time of the survey. Although 80.1 percent were employed full or part-time, 33.2 percent had incomes at or below poverty level. Of those surveyed in the Midwest Study, only 40 percent were currently employed.

Relationships with Family of Origin and Social Support: Both studies found that most of the young adults maintained relationships with members of their families of origin, with many finding themselves living with family at age 19. Of those surveyed in the Midwest study, 63 percent reported feeling close to siblings and half reported being close to their grandparents. Over two thirds reported feeling close to their biological mothers, but many less felt close to their biological fathers.

Improving Outcomes

Staying in care until age 19: The Midwest study compared foster children who exited care at 18 with those who remained until age 19. The results indicated that those who chose to remain under the care and supervision of the child welfare system experienced better outcomes than those who chose, or were forced, to leave care. Young adults who left care at 18 were over 50 percent more likely than their peers still in care to be unemployed and out of school; they lacked health insurance at almost twice the rate of the general population. Those still in care were more likely to be receiving independent living services, staying in school, and to have access to mental heath and health services.

Maintain Placement Stability: Placement stability appears to have a significant impact on the mental health and educational outcomes of foster care youth. The Northwest Study found that the more placements a youth had experienced, the greater the risk of mental health problems. Researchers recommended several strategies to minimize changes in placement

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Outcomes: Former Foster Children

Former foster children are twice as likely to suffer from post-traumatic stress disorder (PTSD) as Iraq war veterans, according to the 2005 Northwest Foster Care Alumni study. More than 20 percent of adults formerly in foster care are doing well, but most face major challenges in the areas of mental health, education, and employment. One-third live at or below the poverty level, and nearly a quarter experience homelessness some time after leaving foster care.

Researchers examined long-term effects of foster care on adults now between the ages of 20-33. The findings were indicative of national trends.

— Many adults who spent time in foster care as children are in fragile economic situations.

— The employment rate for study participants was 80 percent, compared to 95 percent for the general population of a similar age.

— A disproportionate number of youth formerly in foster care completed high school via a GED instead of a high school diploma.

— Completion rates for post-secondary education were also low among youth formerly in foster care.

Source: www.casey.org/MediaCenter/PressReleasesAndAnnouncements/NWAlumniStudy.htm

The Montana Foster Care Independence Program

—Jane Wilson and Samantha Walsh

The Chafee Foster Care Independence Act of 1999 provided funds that allow states to assist youth up to age 21 who have, or will, age out of foster care. The Montana Foster Care Independence Program (MFCIP) provides these services through a contract with Tumbleweed Runaway Program. Foster youth aged 16 or older are referred to Tumbleweed MFCIP for transitional living services. The program provides the education and services necessary to assist youth to obtain and retain employment, housing and enter post secondary education and training institutions. These services include: participation in youth conferences; life skills assessments; developing transition plans; life skills groups and activities; education and training assistance and referrals to available community resources. Once they age out of care, youth 18 to 21 are eligible to continue receiving services, including financial and other assistance necessary to achieve self-sufficiency. They may also receive up to $5,000 per year to attend post secondary education and training institutions.

The Chafee Act requires youth to take primary responsibility for transitioning to self-sufficiency. For this reason, MFCIP is a youth-driven program, and participation is voluntary. The transition plan is developed in full participation with the youth and incorporates the goals and objectives chosen by the youth. Youth are also involved in MFCIP program planning and development, primarily accomplished through the Youth Advisory Council.

Four core principles form the basis of independent living programs for transitioning foster care youth.

— ***Positive Youth Development:*** The practice of providing a variety of services and activities to help youth become socially, morally, emotionally, physically, and cognitively competent (National Resource Center for Youth Development 2004).

— ***Collaboration:*** MFCIP collaborates with several agencies to ensure ongoing quality services to youth in the areas of life skills development, prevention, mental health, housing, employment and education.

— ***Cultural competence:*** MFCIP strives for cultural competence by providing staff training to develop the attitudes, knowledge and skills needed to build trust and communication with each youth.

— ***Permanent connections:*** Youth exiting care are encouraged to develop permanent connections with dedicated adults including mentors, appropriate family members, former foster parents, case workers, and other stable adults who can provide emotional and personal support.

A critical component of the Independent Living Services is life skills development. Generally, learning these skills is a gradual process that occurs throughout childhood. Because of the inconsistency in parenting and education that foster children experience, they usually have less opportunity to develop life skills. For youth in out-of-home placement, life skills development needs to be intentional and specific and to take place throughout the child's life. Adults involved in the lives of foster care youth need to identify and use every possible opportunity to teach these skills (Ansell, Correia, Copeland, Sheehy, Oldham & Zanghi 1999).

A model that offers a four-stage continuum for life skill attainment was developed by Dorothy Ansell of the National Resource Center for Youth Development. It provides youth with the flexibility to learn life skills at their own pace, based on their independent living goals. The four stages are: Informal Learning, Formal Learning, Supervised Practice, and Self-sufficiency. Supervised practice involves supervised independent living situations that lead to self-sufficiency. When a youth reaches self-sufficiency, s/he is ready for discharge (Ansell, Correia, Copeland, Sheehy, Oldham & Zanghi 1999). Sometimes, a youth comes to transition services at or near the time of discharge from care.

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Foster Care in Montana

Children placed in foster care range in age from infants to teenagers. They come from many different backgrounds and reflect the cultural diversity of Montana. At the beginning of 2005, about 1,900 Montana children were in foster care because they had been abused, neglected, or abandoned by their parents or other caretakers.

Many of the children in foster care are insecure, frightened, confused, and angry about what has happened to them. Emotional, behavioral, mental, or physical problems related to the abuse or neglect are common.

Source: www.dphhs.state.mt.us/aboutus/divisions/childfamilyservices/relatedtopics/fostercare.shtml

Aging Out of Foster Care

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while youth are in care. These include helping youth form and maintain healthy relationships, providing better training for foster parents, and managing interventions so that they minimize disruptions.

A study published by the Child Welfare League of America, *Improving Educational Outcomes for Youth in Care* (Yu, Day & Williams 2002) found that every time a child changes placement, s/he loses four to six months of educational progress. Every change in placement causes a disruption in learning for foster care youth. They must struggle to form new relationships with adults and peers, catch up with their classmates, and become oriented to a new school. A study of the educational attainment of foster care youth in Washington State (Burley and Halpern, 2001) found that foster care youth score, on average, 15–20 percent lower on achievement tests than their peers. The study noted that twice as many foster care youth repeated a grade, changed schools or were enrolled in special education than non-foster care youth.

Independent Living Services: The Northwest Study recommended strengthening Independent Living Services by redirecting federal funds to the most promising practices. Their recommendations for best practices for transitioning foster care youth include involving youth in case planning; developing comprehensive transition plans that include relationships with supportive adults, education, community connections, life skills assessment and development; employment experience; and physical and mental health supports.

Sources cited:

Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study, can be found on the Casey Family Programs website: *www.casey.org/resources/p ublications/northwestalumni study.htm.*

Midwest Evaluation of The Adult Functioning of Former Foster Youth (abstract), can be found on the Chapin Hall website: *http://www.chapinhall.org/article_abstract.aspx?ar=1355&L2= 61&L3=130*

9 Elements of Effective Alcohol Treatment for Adolescents

In evaluating a broad spectrum of treatment programs and approaches, researchers have identified common themes among the treatments that are most effective in helping teens. Drug Strategies, a Washington-based nonprofit research institute that promotes more effective approaches to the nation's drug problems, found these key elements in an extensive review.

1. Assessment and treatment matching

2. Comprehensive, integrated treatment approach

3. Family involvement in treatment

4. Developmentally appropriate program

5. Engage and retain teens in treatment

6. Qualified staff

7. Gender and cultural competence

8. Continuing care

9. Treatment outcomes

http://www.ensuringsolutions.org/pages spotlights/respot4.html

Montana Foster Care Independence Program

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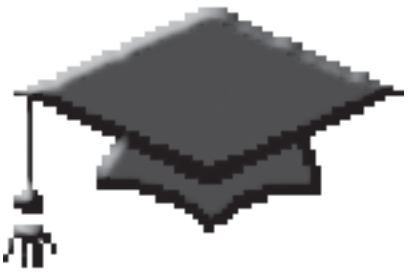
Rather than having the time and flexibility to navigate the four stages of life skill development at a natural pace, they must combine and condense the stages. Youth in these circumstances face more uncertainty because they may be inadequately prepared for the challenges of adult living.

Another key concept of life skill development is the distinction between tangible and intangible life skills. To be prepared for adult community living, young people must acquire both. Tangible life skills include money management, educational and vocational skills, use of community resources and home management. Intangible skills include decision–making, problem solving, conflict resolution, time management, communication and social skills. Intangible life skills form the foundation for tangible life skills.

Transitioning from foster care presents challenges and uncertainties for foster youth that most children don't experience. Studies show that most youth are not fully self-sufficient until age 25. For kids in care, adulthood comes abruptly at age 18 or 19. Most don't have the family support that would provide a safety net. MFCIP services provide a safety net that foster care alumni can access as needed.

Jane Wilson and Samantha Walsh work in the Child and Family Services Program Bureau. For more information, visit www.dphhs.state.mt.us.



Changing the Culture: *Big Brothers Big Sisters*

—Annette Leeland

"It's the best thing I've done at school. I used to be in the resource room when I was little so I kind of knew what he was going through. It felt good to help. I think it's good for both students and totally helps you become a nicer person." —David K., Big Brother and 10th grader at Park High, Livingston

Adolescents are the subjects of much study, generally focusing on problem behaviors (drugs and alcohol, violent behavior and teen pregnancy). Strategies for prevention frequently focus on educating youth about the consequences of risky behaviors, yet the number of students engaging in these behaviors continues to escalate. Students identified as "at-risk" are often singled out as needing extraordinary services that create enormous costs to the social welfare and educational systems.

Big Brothers Big Sisters programs throughout Montana take a different approach. They see high school students, even those traditionally labeled highly at-risk, as valuable resources in creating brighter individual futures for younger children, strengthening schools and building healthy communities. We see them as mentors.

In over 52 communities across Montana, high school students serve as mentors to younger children through Big Brothers Big Sisters school-based mentoring programs. Mentoring sessions combine activities designed to strengthen academics, build self-confidence and develop social and emotional skills (like decision-making and negotiating).

A recent national study was undertaken by Big Brothers Big Sisters of America and Public Private Ventures to establish best practices for school-based mentoring. The study revealed that "programs that encourage activities with a strong social/emotional focus are more likely to have greater *academic* impact, higher quality and longer duration than programs that focus entirely on academics/tutoring."[1] These social-emotional activities (discussing thoughts and feelings, enjoying recreational activities together, creating arts and crafts) are at the heart of the BBBS model, which focuses on relationships. In addition to better grades, teachers report improved classroom behavior and participation—and better peer-to-peer relationships among elementary children mentored by high school students.

While outcomes for Littles are impressive, the impact of serving as mentors on the high school students—particularly those labeled "at-risk"—is often overlooked . . . and profound. Recent research supports this notion. Role theory asserts that people conform to the expectations set for them.[2] Therefore, when adults offer student mentors respect and admiration, they become respectable and admirable. "The experience of being needed, valued, and respected by another person produces a new view of self as a worthwhile human being." [3]

"We help high school kids identify their value systems and share them with someone younger. Most adolescents don't realize that they have established a value system and are surprised during the interview to discover they have. It's empowering for them to articulate their values," explains Teresa Geremia-Chart, Executive Director of BBBS Helena.

"This program has changed the culture of the school," Ken Ballagh, Principal, Gardiner School.

Serving as mentors increases at-risk adolescents' self-concept, improves relationships with peers, reduces absenteeism and improves classroom behavior.[4] Bob Stevenson, Park High School Vice Principal in Livingston, notes, "On mentoring days, we see attendance go way up. The high school kids really look forward to their time with the Littles. It's important to them."

Students are not the only ones who benefit. Where programs have become an institutionalized part of the school culture, the school and the community feel the impact. In Gardiner, a small school with only 85 high school students, 72 are matched with younger children. Ken Ballagh, Gardiner School Principal, says, "This program has changed the culture of the school. It is now just expected that when you get to high school, you will mentor a younger child." He says that he would love to see the program spread throughout the state.

It's definitely a win-win situation. Mentoring decreases the likelihood of engaging in problem behaviors, and at-risk students learn the value of contributing to the community. *The result?* Younger children and their high school mentors have brighter futures. And that's priceless.

For more information on BBBS School-based mentoring programs, contact your local BBBS agency or go to the BBBS Montana website: www.bbbs montana.org.

—Annette Leeland is the Executive Director of Big Brothers Big Sisters of Park County.

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[1] Public Private Venture, *School-Based Mentoring Study, Phase I Report 2003-2004 School Year-Effective Practices,* 2005

[2] Hedin, D. (1987). Students as teacher: A tool for improving school climate and productivity. *Social Policy, 17*(3), 42-47

[3] Ibid, pg 43

[4] Giesecke, D., Cartledge, G., & Gardner III, R. (1993). Low-achieving students as successful cross-age tutors. *Preventing School Failure, 37*(3), 34-43.

The Coalition for a Drug-Free Laurel

—Kellie Gibson, PRC VISTA

—A community bonds to create safe and effective services for youth and families.

The *Coalition for a Drug Free Laurel* is a dynamic group of community members working to create alternatives and services for youth and families. The collaborative partnership includes the Laurel School District, the faith community, local government as well as youth, teachers, counselors, administrators, parents, law enforcement officers and others.

I started as a Prevention Resource Center VISTA for the Laurel School District in January 2005 to provide facilitation and support services to the Coalition. One of the initial steps will involve assessing community need through a web-based survey. This will be administered at the beginning of the 2005-06 school year. It will be available online, in hard copy, at *Back to School Night* events for parents, and during advisory time for students.

An informal assessment of the community's strengths and weaknesses revealed that a large percentage of youth in the Laurel community use alcohol, tobacco and illegal drugs. Other common obstacles revolve around transportation. Traveling the fifteen miles between Laurel and Billings can be a huge obstacle, particularly for those who need such services as chemical dependency treatment or mental health services. On the other hand, part of the community's strength lies in its deep commitment to kids and families. In fact, there are often more people interested in participating than we have the capacity to involve. Friday Fun Nights for middle school students have been so popular that we've had to consider how to meet the needs of all of the kids who want to attend.

The Coalition for a Drug-free Laurel has articulated strengths to build from, and developed three primary goals.

1. **Develop a mentoring program** for students that includes community members, senior citizens, and other students as volunteer mentors. All mentors will complete a training curriculum to ensure success.
2. **Create training** for all school district employees to help them identify student risk behaviors. This training will provide tools for use with students bragging about drug or alcohol use. The Coalition also plans to educate staff on other issues, including depression, suicide and domestic violence. The training will offer a step-by-step process to document behavior, attain services and notify the appropriate personnel to assist the youth and family.
3. **Develop and implement an after-school program** for grades 5-8 that includes academic assistance, opportunities for growth, and fun. The desired outcome is to enhance parental communication and resources.

Program development is a lengthy process, and the Coalition has continued to meet throughout the summer. Funding proposals have been developed and submitted. We continue to develop and tweak ideas.

There have been several other positive steps. In March 2005, we began partnering with the Mental Health Center in Billings. A chemical dependency treatment professional now comes to Laurel twice a week to provide assessments and group therapy for youth. At this time, mental health services are not available locally. We continue to work on closing that gap, and the Coalition hopes to have part-time staff in place by the beginning of the school year. The Coalition is poised to expand: eight local youth each devoted a week of summer break to attending the Teen Institute through the Center of Adolescent Development. They are anxious to participate and to implement the skills they learned.

I am enjoying my experiences in working with this committed and dedicated community on behalf of families and youth at risk. As I tell my children when we are traveling, "getting there is half the fun!"

The Coalition has approached the question, "Where are we going?" as if it were building a pyramid. A strong base will be essential to sustainability.

Scientific Research: the Risks of Experimentation

Drug and alcohol abuse by teens is not something to be taken lightly.

— More teens are in treatment with a primary diagnosis of marijuana dependence than for all other illicit drugs combined.

— A 1998 study by the National Institute on Alcohol Abuse and Alcoholism says if a 15-year-old starts to drink, he or she has a 40 percent chance of alcoholism or dependence as an adult.

— Kids are using marijuana at an earlier age. In the late 1960s fewer than half of those using marijuana for the first time were under 18. By 2001, about two-thirds (67 percent) of marijuana users were younger than 18.

— Marijuana affects alertness, concentration, perception, coordination and reaction time, many of the skills required for safe driving and other tasks. These effects can last up to 24 hours after smoking marijuana. Marijuana use can also make it difficult to judge distances and react to signals and sounds on the road.

— Smoking marijuana leads to changes in the brain that are similar to those caused by cocaine, heroin, or alcohol.

www.theAntiDrug.com

Talking About Touching

—Janice Zabel, BBBS Case Manager

Since 1998, Big Brothers Big Sisters (BBBS) of Butte Silver Bow, the Community Health Center and the Butte School District have trained over 13,000 kids to be safe and to protect themselves from abuse. School leaders have been very receptive to the training. The partnership has taken on the task of training all local children in kindergarten through third grade, as well as the majority of fourth through eighth graders, in abuse prevention. The younger children are trained through the Seattle-based Committee for Children's Personal Safety Curriculum *Talking About Touching* and the older kids using *Respect With Boundaries*, a program designed by BBBS Program Coordinator Phyllis Costello and the BBBS staff.

The training was put in place in 1998. In addition to covering dangerous and abusive situations, the curriculum teaches kids how to ask for help. Some of the topics covered in the 14 lessons include: car, traffic, fire and gun safety, and many aspects of safe and unsafe touch. Costello said that local trainers have added lessons to the national curriculum, including some that focus on the internet.

Community Health Center Therapist, Michelle Miller, has been involved in the Butte program since its inception. She describes it as very effective. "I think one of its most effective points is that it is repeated," Miller said. She explained that while *Talking About Touching* lessons are expanded each year, kids get the core message four years in a row. Another strong point is that the curriculum also talks about other kinds of situations, including fire, gun, and bike safety. Treating sexual abuse as a safety issue makes it easier for kids to talk. The training results in a minimum of two or three disclosures every year.

In 2001, Costello decided to expand the abuse prevention program to fourth through sixth grades, as well as to some seventh and eighth graders. Thus *Respect with Boundaries* was born. The interactive *Respect with Boundaries* program allows kids to discuss the material and share insights and stories. It is linked to the primary abuse program by the continued use of a "support tree" concept that encourages all kids to have three people at school and three people at home whom they can trust, depend upon and confide in. Currently BBBS presents the program at four of the seven elementary schools in Butte and Ramsay and hopes to expand to one more in the fall.

Respect with Boundaries reiterates many points from the primary school training, but adds powerful age-appropriate videos. Fourth graders see a cartoon-based film titled *Standing Up and Taking Responsibility*, which focuses on teaching children that they are the ones best suited and able to speak for themselves. Fifth and sixth graders see *Breaking the Silence*. This reality-based movie, narrated by actress Jane Seymour, features four kids telling their own stories, which include physical, emotional and sexual abuse, as well as a serious case of neglect. These videos, as well as an adult video titled *Easy Targets*, are used by BBBS of Butte as part of their mandatory training for volunteers, parents, and kids.

> ***"Thank you for coming in and talking about the abuses. It was a big help. You taught us the three abuses and we appreciate your help a lot." —Jayde, Grade 3***

Statistics show that kids who are abused may become abusers and/or end up in prison for other offenses. Costello hopes that the in-school training as well as that done at BBBS will eventually help reduce the prison population. "There isn't enough money being put into prevention," Costello said. "We hope these on-going abuse prevention programs will help reduce the growing prison population. Kids need skills to help stop the cycle of abuse."

For more information about BBBS of Butte Silver Bow's abuse prevention programs, contact Costello at www.bbsphyllis@in-tch.com *or phone (406) 782-9644.*

Recognizing Child Abuse

The following signs may signal the presence of child abuse or neglect.

The Child:

- *—Shows sudden changes in behavior or school performance.*
- *—Has not received help for physical or medical problems brought to the parents' attention.*
- *—Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes.*
- *—Is always watchful, as though preparing for something bad to happen.*
- *—Lacks adult supervision.*
- *—Is overly compliant, passive, or withdrawn.*
- *—Comes to school or other activities early, stays late, and does not want to go home.*

The Parent:

- *—Shows little concern for the child.*
- *—Denies the existence of—or blames the child for—the child's problems in school or at home.*
- *—Asks teachers or other caretakers to use harsh physical discipline if the child misbehaves.*
- *—Sees the child as entirely bad, worthless, or burdensome.*
- *—Demands a level of physical or academic performance the child cannot achieve.*
- *—Looks primarily to the child for care, attention, and satisfaction of emotional needs.*

The Parent and Child:

- *—Rarely touch or look at each other.*
- *—Consider their relationship entirely negative.*
- *—State that they do not like each other.*

http://nccanch.acf.hhs.gov/pubs/factsheets/signs.cfm

Disproportionate Minority Confinement

—Cil Robinson

—No topic in the field of juvenile justice can generate heated discussion, or polarize an otherwise cohesive group of people more quickly than disproportionate minority confinement.
—American Prosecutors Research Institute

Minority youth are over-represented at all stages of the juvenile justice system as compared to their numbers in the general population. This was recognized nationally in 1988 when Disproportionate Minority Confinement (DMC) was introduced as an amendment to the federal Juvenile Justice and Delinquency Prevention Act of 1974 (JJDP Act). The National Coalition of State Juvenile Justice Advisory Groups identified that while minority youth do commit slightly higher numbers of violent crimes, the differential incarceration cannot be explained by greater involvement in violent crime alone.

DMC was first identified among Indian youth in Montana through research performed by Nella R. Lee, Ph.D. which was funded by the Montana Board of Crime Control (MBCC). The research encompassed three years of data (1987-1989) on all juveniles processed through the system. Dr. Lee found, "The patterns of discrimination are strikingly similar to those found by other researchers in different states . . . . The results are statistically significant and show racial disparity, not only in arrest rates, but also at other points in the process. . . . Once arrested, Native Americans are disproportionately processed through the system. This speaks to the issue of amplification, but it may be related to juvenile court jurisdiction and organizational settings as well, since judicial districts in Montana showed marked differences in amounts of racial discrimination from the point of arrest on."

In 2000, MBCC funded a follow-up study based on 1999 data and performed by Gary R. Leonardson, Ph.D. Dr. Leonardson's study identified the over-representation of Hispanics and confirmed that over-representation for Indians still existed in Montana's juvenile justice system. Dr. Leonardson found that although there could be many factors (e.g., socio-economic status, arrest profiling, dysfunctional families, lack of programs/facilities, or FAS/FAE) related to disproportionate confinement, American Indians and Hispanics were charged with more serious offenses than others were. The extent of these charges could explain disproportionate confinement and processing for both minority groups.

In 2002 Congress amended the wording of the DMC portion of the JJDP Act from "in confinement" to "in contact with the juvenile justice system." The major reason for the change was the realization that DMC is a multifaceted issue not easily addressed by making changes solely to the juvenile justice system and confinement practices. The causes are complex and best addressed in families and communities prior to contact with the juvenile justice system.

Some court districts in Montana don't have culturally appropriate prevention and intervention programs to which minority youth can be diverted. Some have programs but insufficient capacity to meet the need. Yet others have programs that have not been evaluated. Service providers and educators for adolescents are in the best position to reduce DMC in Montana by being proactive and developing culturally appropriate programs that engage the family.

For technical assistance in gathering data to respond to the assessment questions in the sidebar, or to develop culturally appropriate services for minority youth, contact Cil Robinson, Juvenile Justice Planner at the Montana Board of Crime Control. She can be reached at 406-444-2632 or cirobinson@mt.gov.

After assessing your service area for racial/ethnic make-up, use the following factors to assess need in your service area. Ask whether the responses to the following factors vary by race or ethnicity.

— Racial/ethnic make-up

— Poverty or employment rates

— School attendance/graduation rates

— Local risk and protective factors

— The types of prevention and early intervention services needed and their availability

— Enrollment rates for prevention programming

— Rates at which first-time offenders are admitted to community-based programs

— Rates at which first-time offenders are confined in secure detention

Also consider whether services:

—are culturally appropriate and accessible.

— are best or promising practices.

— engage the family.

Working With Serious and Violent Offenders

—Scott Boyles

Most of the inmates in both Montana prisons have histories of substance abuse. While co-occurring criminal behavior and substance abuse is not new, there is a clear public interest in decreasing the likelihood of re-offending. In many cases, this means addressing substance abuse disorders while changing the behaviors, beliefs and attitudes that originally led offenders to prey on others. There is no doubt that close working relationships between correctional and chemical dependency treatment professionals must be critical components of any successful rehabilitation efforts.

Because corrections professionals, clinicians and psychologists have unique insights and skills that they can each bring to bear in working with this challenging population, learning to work together is essential. At the same time, when two systems as disparate as corrections and chemical dependency treatment work together, it is important to understand the differences in their underlying missions. Once this has been accomplished, it becomes possible to develop common ground.

In Corrections:

- ***Up to 80% of those who are incarcerated have been involved with substance abuse.***
- ***More than 50% of all state prisoners report using drugs or alcohol at the time of their offenses, and at least 38% of violent offenders were using alcohol at the time of their offenses.***
- ***Substance use remains a challenge for 75% of parolees.***
- ***Offenders have two to four times higher rates of mental illness than the general population.***
- ***In 2002, more that 630,000 prisoners—about 1,700 per day—were released from state and federal prisons. If past trends continue, over half will re-offend and be re-incarcerated within three years.***

Underlying Missions Guiding Each System

Criminal Justice	Chemical Dependency Treatment
Public Safety	Public Health
Control & Supervision	Rehabilitation
Accountability	Abstinence
Rehabilitation	Self Help

Substance abuse professional must also understand what works within the criminal justice system. Essential components of contemporary correctional practice include the following principles.

- **Risk Principle:** The intensity of the intervention should match the level of the risk of recidivism.
- **Needs Principle:** For programs to effectively reduce recidivism, they must target offender needs directly related to continued criminal activity.
- **Responsivity Principle:** Services must be delivered in ways that match the learning styles and abilities of the client.

The process of building a bridge between the efforts of the corrections and chemical dependency systems was strengthened in May, when a team from Montana received training in evidence-based practices for working with serious and violent offenders. The training was part of the implementation of a Serious and Violent Offender Reentry Initiative grant awarded to the Montana Department of Corrections. The grant is targeted toward youth, so the team that participated in this training of trainers included staff from Pine Hills and Riverside youth correctional facilities and from the Addictive and Mental Disorders Division. The four individuals who participated will be to train correctional professionals, clinicians and policy makers in the tools, strategies and concepts that are the foundation for working with inmates.

For more information, contact Scott Boyles of the Addictive and Mental Disorders Division at sboyles@mt.gov *or 406-444-9408.*

The National Institute on Drug Abuse has identified 13 key principles for designing effective substance abuse disorder treatment programs:

1. *No single treatment is appropriate for all individuals.*
2. *Treatment must be readily available.*
3. *Effective treatment attends to multiple needs of the individual, not just the drug use.*
4. *An individual's treatment and service plan must be assessed and modified to ensure that it meets changing needs.*
5. *Remaining in treatment for an adequate period of time is critical for treatment effectiveness.*
6. *Counseling and other behavioral therapies are critical components of effective addition treatment.*
7. *Medications are an important element of treatment for many patients.*
8. *Addicted and drug-abusing individuals who have co-occurring mental disorders should have both disorders treated in an integrated way.*
9. *Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.*
10. *Treatment does not need to be voluntary to be effective.*
11. *Potential drug use during treatment must be continually monitored.*
12. *Treatment programs should provide assessment for infectious diseases and counseling to help patients address behaviors that put themselves and others as risk.*
13. *Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.*

The truth™

—Alisha Smith

The Washington, D.C.-based American Legacy Foundation describes its **truth™** tobacco counter-marketing campaign in terms as direct as the campaign itself: "Edgy. Hard-hitting. Unapologetic."

Unlike many youth-oriented substance-abuse prevention programs, which tend to attract the "good" kids one would expect to be against tobacco from the get-go, **truth™** has a rough-around-the-edges look and feel to it that gives it a "bad boys and girls" appeal. This campaign is for youth by youth, targeted to the ages of 12-17. The approach pays off with results.

The single distinguishing characteristic of **truth™** is that it targets the tobacco industry and its products, and exposes Big Tobacco's marketing ploys using the industry's own words and documents.

"Everything had to be the absolute truth, using not our words, but tobacco industry words," American Legacy youth prevention marketing Director Phil Graham recently told the Center for Disease Control and Prevention's Media Network.

The **truth™** campaign was born in Florida in 1998 and rapidly achieved a significant drop in youth tobacco usage rates: From 1998 to 2001, Florida saw an amazing 47 percent decline in youth smoking. A 2003 state health department report found that youth smoking had been cut in half for middle school students and reduced by 35 percent for high school students since the launch of the youth prevention program that included **truth™**. Those numbers equated to 75,000 fewer adolescent smokers. The American Legacy Foundation adopted the **truth™** campaign and took it national.

According to a March 2005 study published in the *American Journal of Public Health* by Farrelly and colleagues, an overall decline of 22 percent in youth smoking between 2000 and 2002 and approximately 300,000 fewer youth smokers in the United States are the result of exposure to the **truth™** campaign. Other studies have shown that counter-marketing campaigns achieve their greatest successes when conducted as part of a comprehensive tobacco prevention program and with the support of youth advocacy movements, much as **truth™** was structured from the outset.

In Montana, where **truth™** ads have run, frequent cigarette use (smoked on 20 or more of the previous 30 days) by high school students declined from 19.3 percent in 1997 to 10.8 percent in 2003, mirroring the national rate of 9.7 percent. However, use of chew tobacco by Montana youth not specifically targeted by **truth™** declined from 21 percent in 1997 to 13.2 percent in 2003, but is still almost double the national average.

While it is a marketing axiom that not every approach nor every message will appeal to all audiences, when California looked at its adult-oriented tobacco-prevention advertising aimed at the 18-55 age range, it also found that its counter-industry spots were most effective in communicating the message and achieving audience awareness.

The California Department of Health Services ran direct anti-industry ads carrying simple counter-marketing messages. The ads were so strong they drew a lawsuit from the tobacco industry. They "hit the mark" with California adults, while health-themed and subtly anti-industry ads, for the most part, were not as effective.

With adolescent audiences, a group normally associated with rebelliousness, it is not a big surprise that carefully crafted messages showing how a large and faceless industry is manipulating and harming them might turn many teens away from tobacco use. One of the tag lines for the **truth™** campaign says it best: "Knowledge is contagious. Infect truth."

That's a "truth" the tobacco industry may find hard to swallow.

—Alisha Smith is an Americorps VISTA serving with the Montana Tobacco Use Prevention Program (MTUPP) within the Montana Department of Public Health and Human Services. She can be reached at 406-444-7373 or by email at alsmith@mt.gov.*

Tobacco Industry Quotes from Internal Documents

***Philip Morris/Altria**: "Today's teenager is tomorrow's potential customer, and the overwhelming majority of smokers first begin to smoke while still in their teens . . . The smoking patterns of teenagers are particularly important to Philip Morris."*

***RJ Reynolds**: "Evidence is now available to indicate that the 14-18 year old group is an increasing segment of the smoking population. RJR-T must soon establish a successful new brand in this market if our position in the industry is to be maintained in the long term."*

***Brown & Williamson**: "Kool's stake in the 16- to 25-year-old population segment is such that the value of this audience should be accurately weighted and reflected in current media programs . . . all magazines will be reviewed to see how efficiently they reach this group."*

***Lorillard Tobacco**: "[T]he base of our business is the high school student."*

***U.S. Tobacco**: "Cherry Skoal is for somebody who likes the taste of candy, if you know what I'm saying."*

Source: http://www.tobaccofreekids.org/research/factsheets/index.php?CategoryID=23

For more information:

— www.americanlegacy.org/

— www.opi.state.mt.us/PDF/YRBS/CompHS.pdf

— www.thetruth.com/

— www.fairenough.com/

Body Art . . . or Self Destruction?

Adolescents sporting multiple piercings and tattoos seem to be everywhere these days . . . girls with diamonds sparkling from their noses, boys with studs through their eyebrows, blue and red tattoos peeking from blouses and decorating young legs and arms—not to mention necks, fingers, wrists, backs, and hands. Some researchers believe piercing, tattooing and other forms of body art are this generation's answer to fashion accessories. Others suggest that, particularly for adolescents, body art may constitute a statement of control or ownership over the body and serve as a means of expressing individuality. Body art can provide a visible means of affiliation with a specific group, or a manifestation of self-destructive impulses. All or none may be correct, depending upon the individual. In this, as everything, whether it's body art or an indication that an adolescent is headed for trouble may be a question of context and degree. One or two ear piercings are certainly less alarming than a black anarcy symbol created by a friend with a razor blade and some ink. In body art, as in any other expression of adolescent identity, there are lines—often fine lines—that delineate the difference between a dangerous risk and the desire to be more attractive or socially acceptable. Even with relatively benign expressions of body art, there are still risks.

Tattoos are indelible markings of pigment placed under the skin. Risks can include:

— Allergic reactions to the pigments.

— Keloid formation. Keloids are raised overgrowths of scar tissue that occur at the site of an injury, and differ from mature scars in composition and size.

— Infection. Bacterial infections around the tattoo can occasionally cause blood, bone, joint and heart infections. Viral infections, including hepatitis, warts and herpes have all been spread by unsanitary conditions during and after the tattooing process.

— Cosmetic changes, including changing shape as skin stretches over time, fading color, and spreading pigment.

— Some dies will actually interfere with Magnetic Resonance Imaging (MRI) tests.

Piercing can be done in a variety of ways, from the use of an automatic piercing gun to the use of a needle or other blunt object. Risks include infection, allergic reactions and keloid formation. There are also complications unique to the body site. Tongue piercings may cause severe swelling, difficulty breathing and swallowing, infection of the mouth and throat, chipped teeth and difficulty chewing or talking. Ear cartilage piercings can take 4–6 months to heal. Navel piercings can also take 6-9 months to heal, and are very likely to become infected because of constant irritation caused by clothing. Piercing of the genitalia can cause serious infections of the urinary tract, pelvic inflammatory disease in women, and urethral/urinary track rupture in men.

Branding is accomplished by heating a metal object and placing it on the skin to leave a scar. Branding can be very dangerous since the intensity of the heat is not known. Underlying muscles and organs can be damaged, so branding should be strongly discouraged.

Sculpturing involves placing an object underneath the skin in order to form a shape or design. This has all the risks of tattooing and piercing and should also be discouraged.

Cutting is occurring more frequently, especially in teenage girls and can be mistaken as a form of body art. Girls deliberately cut themselves with a sharp object, usually a knife. The cutting is usually done on their forearms, but can involve other parts of the body. Cutting is not a form of body art, and is often the sign of serious emotional distress.

Source: http://www.4parents.gov/topics/bodyart_risks.htm

About Marijuana

The Office of National Drug Control Policy's National Youth Anti-Drug Media Campaign includes a compendium of recent research identifying a direct link between marijuana use and increased risk of mental health problems. Recent research makes a stronger case that cannabis smoking itself is a causal agent in psychiatric symptoms, particularly schizophrenia.

Learn more about how marijuana affects the developing teen brain, including the links between marijuana and depression, suicidal thoughts and schizophrenia, at TheAntiDrug.com. Visitors can take a virtual tour of a human brain to learn how marijuana impairs, and even changes, the functionality of the centers responsible for maintaining overall mental health.

Tips for Parents:
It's Not Pestering, It's Parenting

Parents are the first line of defense when it comes to a child's drug use or drinking, and whether it seems like it or not, parents do make a difference. Nearly two-thirds of teenagers see great risk of upsetting their parents or losing the respect of family and friends if they smoke marijuana or use other drugs. Following are some simple steps to help parents.

1. **Set rules**. Let your teen know that drug and alcohol use is unacceptable and that these rules are set to keep him or her safe. Set limits and clear consequences for breaking them.
2. **Praise and reward** good behavior for compliance and enforce consequences for non-compliance.
3. **Know where your teen is** and what he or she will be doing during unsupervised time. Research shows that teens with unsupervised time are three times more likely to use marijuana or other drugs. Unsupervised teens are also more likely to engage in risky behaviors such as underage drinking, sexual activity and cigarette smoking than other teens. This is particularly important after school, in the evening hours, and also when school is out during the summer or holidays.
4. **Talk to your teen.** While shopping or riding in the car, casually ask how things are going at school, about friends or plans for the weekend.
5. **Keep them busy—especially between 3 p.m. to 6 p.m.** and into the evening hours. Engage your teen in after-school activities. Enroll your child in a supervised educational program or a sports league. Research shows that teens who are involved in constructive, adult-supervised activities are less likely to use drugs than other teens
6. **Check on your teenager.** Occasionally check in to see that your kids are where they say they're going to be and that they are spending time with whom they say they are with.
7. **Establish a "core values statement" for your family.** Consider developing a family mission statement that reflects your family's core values. This might be discussed and created during a family meeting or over a weekend meal together. Talking about what they stand for is particularly important at a time when teens are pressured daily by external influencers on issues like drugs, sex, violence, or vandalism. If there is no compass to guide your kids, the void will be filled by the strongest force.
8. **Spend time together** as a family regularly and be involved in your kid's lives. Create a bond with your child. This builds credit with your child so that when you have to set limits or enforce consequences, it's less stressful.
9. **Take time to learn the facts about marijuana and underage drinking** and talk to your teen about its harmful health, social, learning, and mental effects on young users. Visit the drug information area of www.theAntiDrug.com
10. **Get to know your teen's friends** (and their parents) by inviting them over for dinner or talking with them at your teen's soccer practice, dance rehearsal, or other activities.
11. **Stay in touch with the adult supervisors** of your child (camp counselors, coaches, employers, teachers) and have them inform you of any changes in your teen. Warning signs of drug use include distance from family and existing friends, hanging out with a new circle of friends, lack of interest in personal appearance, or changes in eating or sleeping habits.

Source: www.theAntiDrug.com

Signs and Symptoms: A Watch List for Parents

— Changes in friends

— Negative changes in schoolwork, missing school, or declining grades

—Increased secrecy about possessions or activities

— Use of incense, room deodorant, or perfume to hide smoke or chemical odors

— Subtle changes in conversations with friends, e.g. more secretive, using "coded" language

— Change in clothing choices: new fascination with clothes that highlight drug use

— Increase in borrowing money

— Evidence of drug paraphernalia such as pipes or rolling papers

— Evidence of use of inhalant products (such as hairspray, nail polish, correction fluid, common household products); rags and paper bags are sometimes used as accessories

— Bottles of eye drops, which may be used to mask bloodshot eyes or dilated pupils

— New use of mouthwash or breath mints to cover up the smell of alcohol

— Missing prescription drugs—especially narcotics and mood stabilizers

www.theAntiDrug.com

The D.C. Connection

—Theresa Racicot

"Youth drink within the context of a society in which alcohol use is normative behavior and images about alcohol are pervasive." That finding in the Institute of Medicine (IOM) report, *Reducing Underage Drinking: A Collective Responsibility* has encouraged people to take action to change the local culture of underage drinking. By assessing the availability of alcohol to youth and mixed messages sent by adults, community members can take meaningful action to ensure that childhood drinking is not considered a normal part of growing up.

Alcohol is the number one illegal drug of choice for America's children, and kills more of them than all other illegal drugs combined. Slowly, throughout Montana and the Nation, youth alcohol use is being recognized as the serious public health issue it is. The Pacific Institute for Research and Evaluation (2002) has estimated that underage drinking costs the United States $53 billion a year. Underage alcohol use is associated with violence, poor academic performance, suicide, and other risky behaviors. These problems are magnified as the age at which a child begins to drink decreases.

In order to effect change throughout society, everyone needs to participate in the solution. We need to be more aware of the messages we send youth through our personal use of alcohol, as well as the role it plays in the family and community. We need to act together to shift our culture so that alcohol use is not the norm for children and adolescents. Following are some suggestions and tools to help you and your community reduce underage alcohol use.

Almost 75 percent of 7th graders who drink alcohol obtain it from their parents with or without their knowledge (National Research Council, 2003). Look around your home. Are children and adolescents inadvertently receiving the message that alcohol is used to relieve stress or an essential ingredient at every party or event? Make it clear that the alcohol in your home is off limits to children and monitor the supply. Talk with your children and their friends about alcohol, its risks and the potential consequences of early alcohol use. Studies indicate that children are less likely to drink when their parents are involved in their lives**.** Be the change agent in your immediate surroundings. Demonstrate that despite what is portrayed in alcohol advertising, you can have a good time with friends and family without using alcohol.

Look around your community. Understand that it is easier for children not to drink if the community supports that decision. How is alcohol used and viewed within your community? Where are children exposed to alcohol advertisements and where do they get alcohol? Does your community allow alcohol to be served at community events, and if so, how are sales monitored? Are there attractive alternatives to drinking? Are penalties for violation of underage sales laws enforced? Work with local law enforcement to help educate your community about the laws surrounding underage alcohol use, and support the enforcement of those laws.

Get involved. Join or start a community group focused on preventing underage alcohol use. Bring community stakeholders, lawmakers, and retailers together with young people and formulate a plan to change local norms around youth alcohol use. Reward those who make good decisions, highlight the accomplishments of youth who are alcohol free. Help youth guard against peer pressure by arming them with the knowledge of what early alcohol use does to their brains and bodies. To affect the way youth view alcohol use, adults must change their views as well.

Responsibility for the health of America's children lies with all of us—family members, schools and universities, communities, alcohol producers, policy makers, media, medical professionals, opinion leaders—anyone in a position to effect youths' decisions. As co-chair of Leadership's Emeritus Group and President of the Board for the *Leadership to Keep Children Alcohol Free Foundation*, and as a parent, I thank you for your continued hard work. If we each do our part, the solution is within our reach.

Resources

- *Leadership to Keep Children Alcohol Free*, ***www.alcoholfreechildren.org***
- Center for Alcohol Marketing and Youth (CAMY), ***www.camy.org***
- FACE: resources, Training and Action on Alcohol Issues, ***www.faceproject.org***
- Reducing Underage Drinking: A Collective Responsibility, National Academy of Sciences Report, ***www.nap.edu/books/0309089352/html.***

The Last Word

—Joan Cassidy, Chief, Chemical Dependency Bureau

Up until now, the options for adolescents in need of treatment for addiction have been limited in Montana, though we have been blessed with prevention programs and services implemented at the early end of the spectrum. What we need is a full continuum of services that begins at prevention and ends at treatment, one that supports an array of services for all young people—from birth to 21 years of age.

A strong continuum of treatment services for kids includes a good community-based referral system and services that use a group-home setting where teens have the opportunity to continue to gain developmentally. Use, abuse and addiction all have serious impacts on the growth of developmental skills. What is needed for these teens is a system that is manageable for them and for their families. In order to be effective, that means working with the teen at his or her developmental level. Teens need a chance to further their educations, learn to have substance-free fun, gradually find independence in a community setting, and to begin developing core identities through relationships with caring adults and their peers. Abuse and addiction put a stop to all of these things. Teens in recovery must pick up where they left off, and are often working at developmental levels far below what their ages might suggest.

In this issue of the *Prevention Connection* are articles about some exciting new opportunities to help teens address addiction issues. *New Choices* in Billings and the *Teen Recovery Center* in Missoula have opened their doors. Both will provide adolescent-specific treatment, and will be responsive to the developmental needs of the young people they serve. Between them, they will be able to serve 16 youth at a time. Both facilities will be able to deliver services in a fashion that reaches those who need it, using tools that fit the needs of those who will benefit most from them. Ultimately, this means that there are new chances in Montana that will assist young people and their families as they heal. It's a wonderful start.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

*A joint publication of the **Prevention Resource Center** and the **Addictive and Mental Disorders Division***

MONTANA Department of Public Health & Human Services

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